DEPARTMENT OF DEFENSE NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

1. Authorization. I hereby authorize the Department of Defense Nonappropriated Fund Health Benefits Program ("NAF HBP") to use or disclose my health information in the manner described below.

a. Specific description of the health information which may be used or disclosed:

b. The name or other specific identification of the person(s) or class of persons (for example, the NAF HBP or a specifically named human resources office) authorized to use or disclose the health information described paragraph 1.a above:

c. The name of the person(s) or class of persons (for example, the name of a specific office or organization) to whom the person(s) or class of persons named in paragraph 1.b above may disclose the health information described in 1.a above:

d. Description of the purpose of the requested use or disclosure ("At the request of the individual" is a sufficient description if an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.):

2. Understanding. I understand—

a. that I may revoke this authorization at any time prior to its expiration, except to the extent that the NAF HBP has already taken action in reliance upon this authorization;

b. that if I wish to revoke this authorization, I must do so by notifying the NAF HBP Privacy Official for NAF employer;

c. that the NAF HBP may not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

3. Expiration of Authorization. This authorization will expire on _____.
(Indicate an expiration date or an expiration event that relates to you or to the purpose of the authorized use or disclosure.)

_____ _____
Signature Date

_____ _____
Name (Print) Telephone Number

If your representative signs this authorization, provide a description of his authority to act for you:_____
_____
_____.